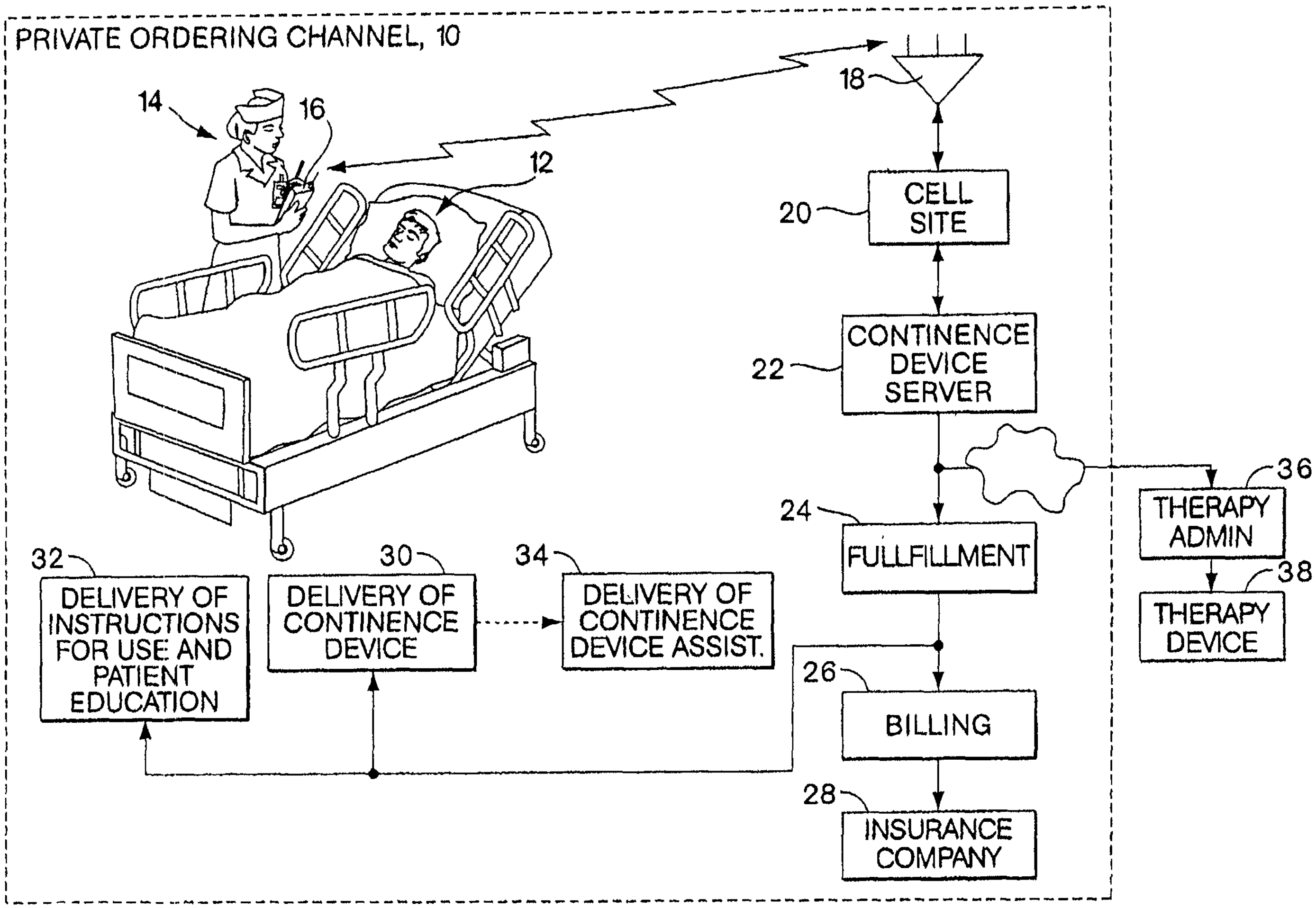
PRIVATE ORDERING CHANNEL, 10
14
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CELL SITE
22
CONTINENCE DEVICE SERVER
24
FULLFILLMENT
26
BILLING
28
INSURANCE COMPANY
36
THERAPY ADMIN
38
THERAPY DEVICE
32
DELIVERY OF INSTRUCTIONS FOR USE AND PATIENT EDUCATION
30
DELIVERY OF CONTINENCE DEVICE
34
DELIVERY OF CONTINENCE DEVICE ASSIST.

Fig. 1

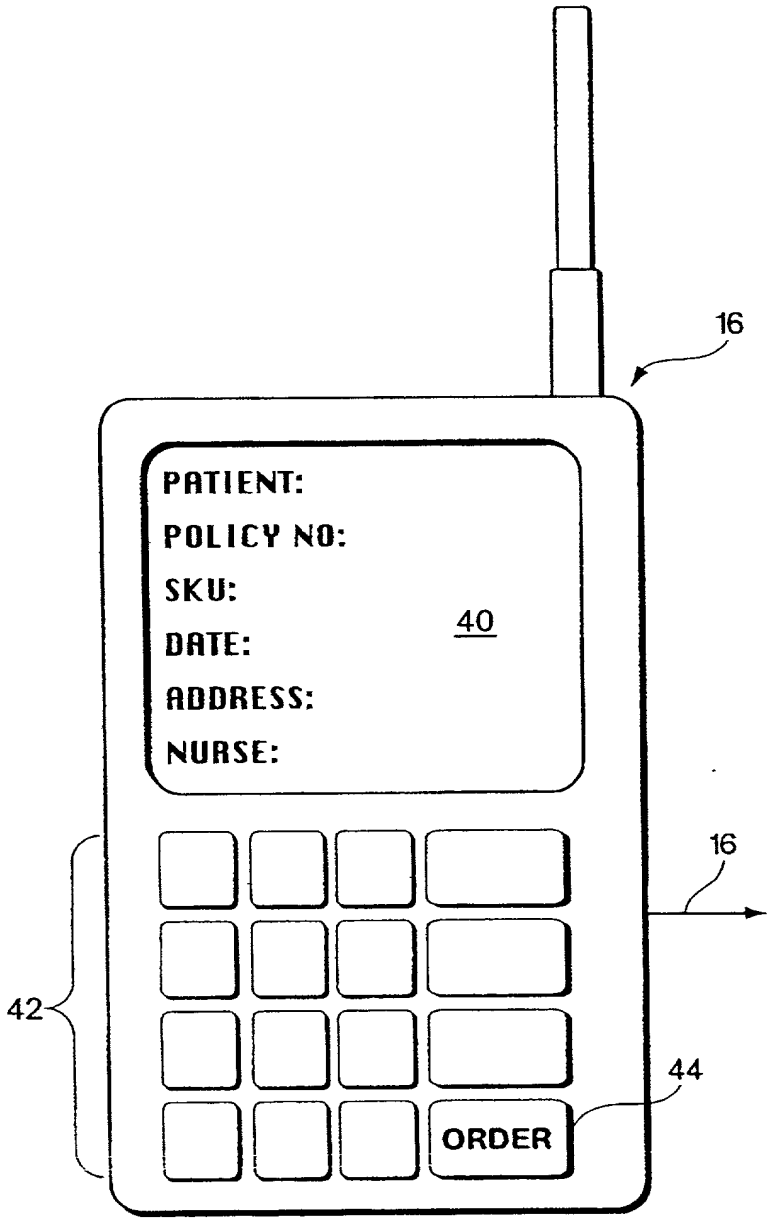

Fig. 2

Health Insurance Information

Primary Health Insurance

Insurance Company Name:
Employer Sponsor:
Insurance Address:
Mailing:
City:
State:
Zip:
Subscriber relationship to patient: ○Self ○Spouse ○Parent ○Other
Subscriber Name:
Certification ID #:
Policy Group or Plan #:

Secondary Health Insurance

Insurance Company Name:
Employer Sponsor:
Insurance Address:
Mailing:
City:
State:
Zip:
Subscriber relationship to patient: ○Self ○Spouse ○Parent ○Other

Subscriber Name:
Certification ID#:
Policy Group or Plan #:

Fig. 3

Insurance Authorization and Assignment of Benefits

Please Read:
All charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization .

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangement have been made in advance Witty our office.

I hereby authorize and direct payment to _____ of all medical/surgical benefits due on any unpaid bills for services provided to me by this physician.

I also authorize release of any information necessary for processing of this or a related claim.

Signature: _____
Date: _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services provided to me by that physician.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above named practice any information regarding my Medicare claims under title XVIII of the Social Security Act.

Signature: _____
Date: _____

Fig. 4

N ew Patient Information Form

Physician:
Date:
Referring Physician:
Patient Complaint or Diagnosis:

Patient Information

Name:
Age:
Date of Birth:
SS#:
Sex: ○ Male ○ Female
Marital Status:

Home Address

Street:
City:
State:
Zip:

Mailing Address

Street:
City:
State:
Zip:
Home Phone:
Business Phone:
Employer:
Name:
Address:
Responsible Party: ○Self or
Relationship
Name:
Phone:
Street:
City:
State:
Zip:

For Emergency Contact Nearest Relative or Friend

Relationship
Name:
Phone:
Street:
City:
State:
Zip:
Healthcare Proxy: ○Yes ○No

Fig. 5

Health History Questionnare

Please help us assess your healthcare needs by taking a few moments to fill out this questionnaire. Some questions may not apply to you, but we ask the same quesiions of everyone. If you prefer to discuss any particular question in person circle it or leave the answer blank.

All answers are confidential.

Name:

Today's Date:

Age:

MaritalStatus:

Sex: ○Male ○Female

Referring MD:

Present Health Concern or Complaint:

Symptoms

○Frequency	○ Hesitancy	○ Fever
○ Noctura	○ Urgency	○ Chills
○ Inteimittency	○ Urge Incontinence	○ Prostatatis
○ Hematura	○ Stess Incontinence	○ Dribbling
○ Strain to void	○ Dysura	○ Stones
○ Force of stream	○ Sensation of incomplete emptying	
○ UTI	○ Pain	

Fig. 6

Past Urological History

Sexual History:

Do you have concerns about your sexual function?

Other:

Past Medical History:

Please list all past and present medical conditions, hospitalizations, surgeries, illnesses or injuries.

Illness/Surgery/Injury/Condition	WhereTreated	Physician	Date

In particular} have you had any of the following?

○High Blood Pressure	○Stroke	○Kidney Stones
○Heart Disease	○Ulcer	○Thyrold Disorder
○Back Problems	○Glaucoma	○Tuberculosis
○Anemia	○Seizures	○Gout
○Asthma	○Jaundice	○Arthritis
○Cancer	○Lung Problems	○Hemorrhoids
○Phebitis	○Bleeding Problems	○Bladder Infection
○Rheumatic Fever	○Gall Bladder Problems	○Intestinal Problems
○Rectal Bleeding	○Prostate Problems	○ Diaiabetes
○Edema		

Do you have difficulties with:

○Kidney Stones	○Blood in Urine	○Leaking/Losing Urine
○Painful Burning Urination	○Bladder Infection	
○KidneyInfection	○Starting/Stopping Urinaiion	
○FrequentlUrgent	○Urinate During the Night	
○Swelling/Pain in Testicles	○Bed wetting	

Fig. 7

List Current Medications

(include vitamins and other over the counter medications):

Medications(Current)	Dose and Frequency

Allergic Reactions to Any Food or Medications:

Food or Medication	Reaction

Smoking/Alcohol History:

Do you, or have you ever smoked cigarettes, cigars or pipes

○Yes

○ No

If you quit, date: [ ]

Cigarette packs per day: [ ] Number of years [ ]

Number of cigars per day: [ ] Number of years [ ]

Bowls of pipe tobacco per day: [ ] Numer of years [ ]

How many drinks do you have a day?

beer [ ] wine [ ] liquor [ ]

For how long? [ ]

Fig. 8

Family History

Has anybody in your immediate family been diagnosed with the following? **Please list family member:**

Diagnosis	Family Member
○Allergies	
○Asthma	
○Diabetes	
○Cancer/Tumor (Type)	
○Thyroid Disease	
○Seizure	
○Eye Problems	
○Genetic Disease	
○Alcoholism	
○Kidney/Bladder Problems	
○Ulcer	
○Arthritis	
○Heart Problems	
○High Blood Pressure	

Fig. 9